Washington State Department of Social & Health Services

Dennis Braddock, Secretary

2001-03 Medical Financing

May-June 2002

Medicaid Reform in Washington State

The search for more flexibility and better management tools to deal with rising costs

Town Hall Schedule

DSHS invites stakeholders, clients, health-care providers and others to comment on the proposed amended waiver at the dates and times listed:

May 21, Spokane
6 to 9 p.m.
Sacred Heart Medical Center

May 22, Olympia
6 to 9 p.m.
Town Square Complex
Plum and Union, Building 2,
First Floor Training Room

May 28, Tacoma
6 to 9 p.m.
South Park Community Center
Conference Center (First Floor)

May 30, Bellingham
6 to 9 p.m.
Garden Street Family Center
Conference Room

June 5, Port Angeles
6 to 9 p.m.
Vern Burton Center

June 6, Seattle/Everett
6 to 9 p.m.
Shoreline Community College

June 11, Tri-Cities
6 to 9 p.m.
Columbia Basin College

June 12, Yakima
6 to 9 p.m.
Epic Center

June 18, Vancouver
6 to 9 p.m.
Educational Service District 112

June 20, Seattle/Des Moines
6 to 9 p.m.
Highline Community College

Registration is not required. All Town Hall meetings are free and open to the public.

Washington residents also can comment on the waiver proposal by mailing written testimony to:

Medical Assistance Administration
ATTN: Medicaid Waiver/Rich Pannkuk
P.O. Box 45500, Olympia, WA 98504

Or send comments via e-mail to:
pannkre@dshs.wa.gov

WHY REFORM? Washington State has been a national leader in providing health care to its children, vulnerable adults, and the working poor for decades. In a time of lower health care costs and more state funding, the state was able to expand coverage. But now health costs are increasing significantly, and the demand for coverage and services continues to grow. State funding sources are not able to keep pace. The inescapable conclusion is that new strategies are needed in not only in the coming years, but now.

A System in Crisis

Residents don't have to look far to see that the entire health care system is in trouble. The Department of Social and Health Services (DSHS) provides medical assistance to more than 900,000 Washington residents each month, and the weight of those costs has reached a budgetary milestone – rising now at the rate of a half billion dollars a year. Medicaid programs today consume more than 40 percent of the total DSHS budget – and seem destined to eventually crowd other social services off the agenda. In addition, reimbursement levels are leading some physicians to limit Medicaid patients. In fact, DSHS already has some eligible clients who have had difficulty accessing providers.

The Background

The Department of Social and Health Services' Medical Assistance Administration (MAA) recognized this fact. MAA initiated a series of Community Conversations across Washington in 2001 to begin the discussion of these systemic problems. In the fall of 2001, MAA unveiled its first draft version of a demonstration waiver aimed at giving the state new flexibility in dealing with the cost squeeze currently afflicting Medicaid programs. In subsequent meetings with stakeholders, clients, legislators and the federal Centers for Medicare and Medicaid Services (CMS), it became clear that the initial waiver proposal needed revision. Critics who felt the waiver proposal went too far and those who felt it did not go far enough agreed on one thing: MAA would never get needed flexibility without being more concrete about the circumstances in which it would use that flexibility. With that conclusion, MAA went back to the drawing board to rephrase the waiver proposal.

The Amended Waiver

The new waiver will be submitted to CMS in July 2002. In the interim, MAA will sponsor a series of town meetings across Washington to sample public opinion on the waiver issues and to encourage feedback on potential solutions to the state's serious funding crisis. The new waiver plan will likely be submitted as a Health Insurance Flexibility and Accountability (HIFA) demonstration.

Washington: The Bellwether State

Children

The Legislature authorized three major expansions of health coverage for low-income children during the past decade. As a result, enrollment in children's Medicaid programs increased 12.5 percent per year between 1996 and 2001. It is projected to increase another 7.5 percent during the next two years.

Pregnant Women

The Medicaid-financed First Steps program was implemented in 1989 to provide health-care coverage to pregnant women and infants in households up to 185 percent of the federal poverty level. Currently, Washington's Medicaid program covers two in every five births in the state. In addition, Washington State Medicaid funds are targeting a reduction in unintended pregnancies by offering free family planning and education services to low-income residents.

Seniors

Many low-income seniors have sought Medicaid coverage to offset the growth in health-care costs, especially prescription drugs and medical equipment. (Neither of these is covered by Medicare.) Monthly per capita expenditures for prescription drugs for low-income seniors jumped from $118 in fiscal 1996 to $172 in fiscal 2001 – an annual increase of about 9 percent. As a result, DSHS caseloads for the elderly increased 12 percent a year between 1996 and 2001. The trend is expected to continue in the current biennium.

NOTE: The waiver proposal for Washington does not affect Medicaid's Long-Term Care benefits, which rank among its highest costs.

Questions About the Waiver?

Check out the web page:
http://maa.dshs.wa.gov/medwaiver

FOR MORE INFORMATION:
Jim Stevenson, PIO
360-902-7604
stevejh2@dshs.wa.gov

Persons with disabilities or special needs may call **360-902-7604** or e-mail stevejhs2@dshs.wa.gov and request a hard copy.

Keys to the Waiver

In seven key ways, the Medicaid reform would deal with the squeeze on Washington's budget and Medicaid families:

An Enrollment Freeze

Under the amended waiver, the state would set trigger points based on the periodic caseload forecasts conducted for state government. When trends reached those trigger points – indicating that expenditures were now exceeding program forecasts, MAA would implement enrollment freezes on its optional programs but continue coverage for residents already enrolled. New applicants for optional programs would have to wait until the freeze was lifted before they could enroll in the programs and receive coverage. Clients in mandatory Medicaid programs would continue to receive services as before, and applicants who meet those eligibility standards would be enrolled without waiting.

Cost Sharing

Optional clients whose income totals more than the Federal Poverty Level (FPL) would have to share the cost of their coverage with small premiums. The amended waiver would not set total cost-sharing for premiums and co-payments higher than 5 percent, on average, of a family's income. The premiums would not apply to any Medicaid clients with incomes below 100 percent of the Federal Poverty Level.

Co-Payments

To provide incentives for appropriate use of medical services, all MAA clients would face the prospect of co-payments in two selective circumstances:

- Clients who insist on more expensive, brand-name drugs would have to pay a small co-payment (about $5 per prescription) when there is a lower-cost generic or therapeutic equivalent preferred drug. The co-pay would not apply if the brand-name drug were medically necessary or there is no equivalent drug.
- Clients who visit emergency rooms for non-emergent reasons would also have to pay a small co-payment (about $10) to receive treatment.

Benefit Redesign

Under the waiver, Medicaid would be allowed to redraft the benefit package for adults in optional programs to eliminate dental, vision and hearing benefits, bringing them more in line with the Basic Health benefits (plus outpatient therapies) under a health-coverage program already in effect for the working poor. Children would continue to receive full-scope Medicaid coverage.

Full Use of Currently Unused Federal Funds

The amended waiver also would let DSHS and the Health Care Authority (HCA) use unspent federal funds from the State Children's Health Insurance Program (SCHIP) to complement other medical assistance needs. These funds would permit covering parents of Medicaid children enrolled in the Basic Health Plan or childless adults. Under current rules, Washington must return unspent funds, which then go to other states.

Tribal Exemption

The amended waiver also includes a request that American Indians and Alaska Natives be exempted from the co-payment and premium requirements. This provision would avoid conflict with existing agreements between the state Medicaid program and tribal clinics.

Budget Neutrality

The waiver's budget neutrality requirements would be based on an assurance that the waiver would not cover any new eligibility groups or services that are not otherwise permitted under a Medicaid State Plan.

Premiums and Co-Pays: The Basic Health Model

The idea of subsidized health insurance for the poor is not new. Washington State's Basic Health program was a pioneer effort to provide affordable family health care when it was created in 1988.

Throughout its history, Basic Health has expected beneficiaries of the program to participate in the cost of their medical coverage and treatment. That contribution is minimal at the very lowest incomes – as low as $10 a month – but increases substantially toward the top of the eligibility limits – 200 percent or more of the Federal Poverty Level (FPL).

Washington's SCHIP, Medicaid Buy-In and Transitional Medical Assistance (TMA) programs already have premium requirements.

Medicaid reform proposes to apply this principle to other Medical Assistance programs. Under the waiver, some Medicaid clients with incomes above the poverty level would pay a reasonable premium to help with the expense of their medical assistance. No clients below FPL would have to pay premiums.

An Anticipated Timeline for Medicaid Reform

- **November 2001:** The initial proposed demonstration waiver was submitted in early November to the federal Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration, or HCFA).
- **January-April 2002:** Discussion of the waiver occurs during the 2002 Legislative Session and between MAA and federal officials with CMS
- **April 2002:** Assistant Secretary Doug Porter decides the state will redraft the proposal and resubmit it to CMS.
- **May-June 2002:** A series of Town Meetings are planned throughout the state to give stakeholders, legislators, clients, and the public an opportunity to comment plan.
- **July 2002:** Amended waiver to be submitted to CMS.
- **December 2002:** Anticipated approval of amended waiver by CMS
- **January 2003:** Legislature convenes to pass budget and necessary legislation.
- **July 2003:** Implement Medicaid reforms under approved waiver.

Goals of Medicaid Reform

- Ensure that the most vulnerable populations retain access to full-scope Medicaid coverage
- Demonstrate how more flexibility can allow the state to avoid reducing existing coverage.
- Adopt cost-sharing, benefit changes and enrollment freezes to protect current enrollees.
- Use the state's unspent State children's Health Insurance Program (SCHIP) funds to expand Basic Health coverage for additional low-income parents and childless adults.

Consequences of Not Receiving Waiver Approval

When projected program costs exceed revenue forecasts, the state will have few options:

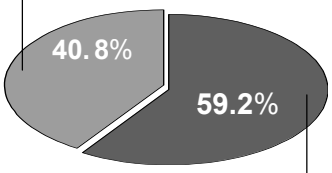
- Increase Medicaid program funding with new funding sources
- Reduce payments to providers
- Eliminate entire programs or eliminate services

The Medicaid-SCHIP Reform Waiver

Medicaid is divided between the Mandatory eligibility groups (mostly individuals and families below Federal Poverty Level) and Optional groups of low-income workers, where incomes may be twice the poverty level – or even higher.

Low-Income Workers:

Category includes children and pregnant women in working families above the poverty level and working disabled persons. Like their counterparts in the Basic Health program, **these clients may be assessed small premiums – but the total assessment is not expected to exceed 5 percent of their income.**



The Most Vulnerable:

Families at or below the Federal Poverty Level would not have to pay premiums or lose any mandatory services, which include hospital care, physician visits, nursing facility, home health care, family planning or any services diagnosed as needed by children.

CHILDREN OF ALL AGES: Low-income children are protected by federal law from any barriers to care, although they may be assigned small co-pays.

PREGNANT WOMEN and NEWBORNS: Low-income pregnant women will be insulated from paying premiums under the waiver.

ELDERLY, BLIND AND DISABLED: Mandatory services would not change, although they could be assigned small co-pay under the waiver.

REFUGEES, NURSING HOMES: People granted asylum by law receive medical care. Also unchanged: The commitment to provide long-term care for the aged and disabled.

Federal Poverty Levels

Family Size	Annual Income
1	$ 8,860
2	$11,940
3	$15,020
4	$18,100
5	$21,180

Washington's Medical Assistance Programs

In 1965, Congress created the Medicaid program to provide the means by which states and federal governments could pool their funds to provide health care for low-income Americans. Initially, Medicaid in Washington state had an enrollment of only a few thousand. But over time Medicaid has grown significantly, and the past decade has seen especially rapid growth. In the last 12 years alone, Medicaid enrollment in Washington jumped from 400,000 to 900,000 people.

Enrollment growth has a number of causes:

- Medicaid coverage has been expanded over the years to additional categories of people.
- The number of people with private health insurance is continuing to decline.
- Loss of manufacturing jobs as the state shifts to a service economy.
- Federal incentives and matching funds have been available.
- The growth also includes growing numbers of low-wage working people whose employers could not afford to provide coverage, as well as rising numbers of elderly unable to pay for their own long-term care.
- It also reflects a long-term strategy by Washington, other states and the federal government to locate uninsured children and try to make sure they receive preventive care that will translate into better health later in life.

All of these factors have created pressure to shelter more and more people under the Medicaid umbrella. Today, one in three Washington children is covered by Medicaid, and more than 40 percent of the births in the state fall under Medicaid. This rapid growth in Medicaid enrollment has been matched in recent years by the fact that Medicaid costs are also rising rapidly. The federal government still pays about half of these total costs, with the rest picked up by the state.

But as overall costs rose, the state's share of the bill has grown larger, too, and in recent years, medical assistance has begun to compete with other state services for state spending. In the 2001-03 state budget cycle, Medicaid expenses will total $5.4 billion. Today, the state's share of Medicaid expenditures alone represents a full 10 percent of the state budget.

Costs are rising as much as a half billion dollars a year. Unfortunately, the state revenue sources that support medical assistance are growing much more slowly – and just as important, below expectations. The March 2001 forecast of $22.2 billion in state revenue to support the state's 2001-03 budget funds declined more than $1 billion by the November 2001 forecast. With recession and spending limits, state economists predict continued declines before the state sees an upturn.

Characteristics of Washington's Medical Assistance Population

By enrollment … as of January 2002

MANDATORY	
CN Family Medical	272,106
CN Mandatory Aged	22,466
QMB, SLMB, ESLMB cost-sharing	11,632
CN Mandatory Blind and Disabled	79,489
CN Pregnant Women	16,723
CN Mandatory Children*	166,357
CN Foster Care and Adoption Support	15,387
Refugee	958

OPTIONAL	
CN Optional Aged	30,380
MN Aged	5,736
CN Optional Blind and Disabled	32,443
MN Blind and Disabled	7,942
CN Optional Breast/Cervical Cancer	86
CN Optional Medicaid Buy-In	2
MN Children/Pregnant Women	61
CN Optional Children	143,201
SCHIP 200% to 250% of FPL	6,543
Family Planning, including Take Charge	63,093

STATE-FUNDED	
Family Medical for Aliens	3,386**
CHP Undocumented Children	20,655**
Medically Indigent	1,992
MCS GA-U	9,367
MCA ADATSA/Unemployable (GA-U)	3,667
Pregnancy Coverage for Aliens	6,428

Total medical assistance eligible: 920,100 Total mandatory: 585,118 (64%) Total optional: 334,982 (34%)
(*) Infants ≤ age 1 ≤ 185% FPL, children age 1-5 ≤ 133% FPL, children age 6-18 ≤ 100% FPL
(**) Program coverage transfers to the Health Care Authority's Basic Health program effective October 1, 2002

By services…

MANDATORY SERVICES
Inpatient hospital services
Outpatient hospital services, including emergency room
Rural health clinic services
Federally-qualified health center services
Laboratory and x-ray services
Nursing facility services for individuals age 21 or older
EPSDT for individuals under age 21
Family planning services and supplies
Physician services and medical/surgical dentist services
Nurse-midwife services
Home health services
Nurse practitioner services
Emergency services for non-citizens
Pregnancy-related services
Transportation, including ambulance

The groups and services listed on this page illustrate choices Washington state has made for our citizens. Mandatory groups and services are those the federal government requires. The optional categories on the right reflect state decision-making. The waiver would allow the state to eliminate a few optional services for adults, such as dental, hearing, and vision. It would not change long-term care or institutional benefits for the aged or disabled. Children's benefits also would be unchanged.

OPTIONAL SERVICES
Adult day health
Audiology
Blood/blood derivatives/blood administration
Maternity case management for high-risk clients
Chiropractic care under EPSDT
Community mental health centers
Dental services
Dentures
Detoxification
Drugs and pharmaceutical supplies
Durable medical equipment
Eyeglasses and eye exams
Hearing aid
Home- or community-based for elderly, blind, disabled
Hospice care
Inpatient psychiatric services for persons under 21
Intermediate care facility for the mentally retarded (ICF/MR)
Interpreter services
Involuntary commitment
Neurodevelopmental centers
Nutrition therapy under EPSDT
Optometry
Organ transplants
Orthodontia
Oxygen/respiratory therapy
Chronic pain management
Personal care services
Physical, speech & occupational therapy
Physical medicine and rehabilitation
Podiatry
Private duty nursing
Prosthetic devices and mobility aids
School medical services
Outpatient substance abuse
Parenteral and enteral nutrition services
Targeted case management
Maternity support services